Appalachian Regional Healthcare System

Financial Assistance

Name: ____ Date: ______________

Applications for Financial Assistance will not be accepted more than 9 months after the date the patient or applicant becomes responsible for the balance of the patient's account.

Patients applying for Financial Assistance from Appalachian Regional Healthcare System (ARHS) must be public screened for government assistance including Medicaid or insurance through the marketplace.

To be considered for Financial Assistance the applicant and spouse, if applicable, must submit to ARHS a fully completed Financial Assistance Application with proof of current household income and /or assets which may include but may not be limited to:

- Paycheck stubs - 2 most recent
- Social Security Statements - (one year prior & current year)
- Retirement income
- Alimony and/or Child support
- Veteran's payments or Military family allotments
- Unemployment compensation checks or direct deposit
- Verification of public assistance including Food Stamps & Aid to Families with Dependent Children
- Dividend, interest, rental income
- Net gambling or lottery winnings
- Checking account statements - 2 most recent
- Savings account statements - 2 most recent
- Stocks & bonds
- Certificates of Deposit
- Cash
- Cash value of life insurance
- Tax Return with W-2's and 1099's

In addition a statement in writing and signed by the application will be required from any individual providing residence and/or sole support of the applicant.

The Financial Assistance Application must be completed with all information including copies of above listed documentation which apply to the applicant household. The applicant and spouse, if applicable, must sign and date the application.

For questions or information please contact our:
Patient Financial Advocate at ARHS Patient Financial Services (828) 262-4110

APPALACHIAN REGIONAL
HEALTHCARE SYSTEM

Financial Assistance Application

Patient Demographics:

Applicant Name: ______________________ Spouse Name: ______________________

Applicant Address: ____

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

List the members of your household and their dates of birth: *(Household includes the applicant, spouse and children less than 18 years of age who are claimed as dependents on your income tax return.)* Please attach a separate sheet to list additional household members.

Applicant: ____________________ Date of Birth: __________

Name: ______________________ Date of Birth: __________ Relationship: ______________

Name: ______________________ Date of Birth: __________ Relationship: ______________

Name: ______________________ Date of Birth: __________ Relationship: ______________

Name: ______________________ Date of Birth: __________ Relationship: ______________

Have you applied for or are receiving assistance from another source? (Please circle appropriate response below)

Medicaid	Yes	No	If yes, please circle	Accepted	Denied
Appalachian Healthcare Project	Yes	No	If yes, please circle	Accepted	Denied

In the event an applicant has no income, assets and/or expenses the applicant will be required to include with his/her application a statement disclosing the lack of income, assets and/or expenses. Additionally the applicant will be required to provide a statement from any individual(s) providing housing and/or sole support to an applicant disclosing the provision of such support.

Income:

Prior Year Income:

Did you file a tax return last year? (Please circle appropriate answer)

Yes Please provide copy of tax return.

No Reason: ______________________ Please provide evidence of prior year income if any.

In the event no income was received in the prior year please provide an approved witnessed statement to that effect.

Current Year Income: Please enter "N/A" in any which do not apply to your household. Please indicate whether Monthly or Annual income by circling one choice. (Current income may be evidenced by two (2) most recent stubs or in the event of direct deposit two (2) most recent bank statements except for gross wages which must be evidenced by two (2) most recent pay stubs even when direct deposited)

Applicant's Employer: ______________________ Gross Wages: $__________ Monthly Annually

Must provide 2 most recent pay stubs or statements, may not use bank statements

Spouse's Employer: ______________________ Gross Wages: $__________ Monthly Annually

Must provide 2 most recent pay stubs or statements, may not use bank statements

Social Security:	$____________	Monthly	Annually
Retirement Income:	$____________	Monthly	Annually
Unemployment compensation:	$____________	Monthly	Annually
Veteran's payments or Military family allotments:	$____________	Monthly	Annually
Public / Government Assistance : (including food stamps and Aid to Families with Dependent Children)	$____________	Monthly	Annually
Alimony and/or Child Support:	$____________	Monthly	Annually
Rental Income:	$____________	Monthly	Annually
Dividends and/or Interest from Investments:	$____________	Monthly	Annually
Net gambling or lottery winnings:	$____________	Monthly	Annually
Other income:____	$____________	Monthly	Annually

(Please attach a separate sheet to list any additional sources of income).

Total Monthly Expenses (Loans, utilities, medical, etc): $________________

Assets: Indicate whether individually or jointly owned by circling one choice.
Cash: Please attach two (2) most recent statement(s) which support disclosed balance(s).

Checking Account:	$_____________	Balance as of _________	Individual	Joint
Savings Account:	$_____________	Balance as of _________	Individual	Joint
Certificates of Deposit:	$_____________		Individual	Joint
Stocks and/or Bonds:	$_____________		Individual	Joint
Annuities:	$_____________		Individual	Joint
Retirement: (includes 401K, 403B, IRA, etc)	$_____________		Individual	Joint
Cash Value of Life Insurance	$_____________		Individual	Joint

Real Estate: Please attach property tax statements

Primary Residence	☐ Rent	☐ Own	Monthly Payment: $________________
Secondary Residence	☐ Yes	☐ No	
Other Real Estate (Rental Property)	☐ Yes	☐ No	

CERTIFICATION:

I certify that all information provided on this application is complete and true to the best of my knowledge. I am aware that providing false information may result in my eligibility being revoked and the balance of the patient account(s) to which this eligibility is applied being subject to standard collection efforts of ARHS, including but not limited to placement with a collection agency. I authorize the release of any financial information requested by Appalachian Regional Healthcare System, pertinent to the consideration of this application.

Signature of applicant: ____________________________(Seal) Date:____________________

Signature of spouse: ______________________________(Seal) Date:____________________